Alven M. Weil, MBA
Director, PR & Communications
Premier healthcare alliance
13034 Ballantyne Corporate Place
Charlotte, NC 28277
P: 704.816.5797
Cell: 704.995.5607
F: 704.816.5797
alven_weil@premierinc.com
Premier In the News: www.premierinc.com/about/news/inthenews/index.jsp

Based on our experience with the Hospital Quality Incentive Demonstration (http://www.premierinc.com/quality-safety/tools-services/p4p/hqi/index.jsp) (HQID), the Premier healthcare alliance strongly supports policies that link payment to quality outcomes. However, we are disappointed that CMS essentially ignored comments from the field on the proposed Medicare value-based purchasing (VBP) rule and did not adjust its policies accordingly.

CMS has inappropriately weighted the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. While inclusion of HCAHPS is an important advancement of patient-centered care, a 30 percent weighting is excessive, since research shows that high-acuity or depressed patients score their experience at a lower level. Because of this, we believe that CMS' policy will disadvantage hospitals that take on complex patients.

Premier has long argued that performance thresholds should be established at a level that all hospitals reasonably could be expected to achieve. Setting the threshold at the median in the baseline period is overly ambitious in the first year of the program, failing to take into account the time needed to establish robust quality improvement infrastructures. Moreover, a median threshold will result in major and immediate payment shifts, particularly for teaching and safety-net hospitals, which will experience significant losses under the proposal. CMS should instead transition to higher thresholds over time, revisiting it each year as new measures are added.

As stated in previous comment letters, Premier supports the inclusion of harm and healthcare-acquired condition (HAC) measures in VBP. However, the VBP measures are duplicative of CMS' current non-payment policy. CMS needs to reconsider its overall approach to HACs to ensure that each policy is mutually exclusive and hospitals are not inappropriately hit with double penalties for the same event. Furthermore, such quality measures based on billing data are unreliable and should not be used; instead, CMS should wait for inclusion of more robust clinical outcomes measures.

We were disappointed with the selection of the Agency for Healthcare Quality and Research (AHRQ) patient safety and inpatient quality indicators in the VBP program. These measures do not have substantial evidence to support their ability to identify true differences in hospital performance, and some have very high false positive rates. Using "buggy" measures to determine payment is highly inappropriate, and will unfairly penalize hospitals with reduced reimbursement - even in cases where no quality or safety events have occurred.

Regards,